

## Claim Submission Instructions

**Complete All Sections:**

Fill out the claim form in BLOCK CAPITALS.  
Sign and date the back

**Submit Within 6 Months:**

Include receipts or supporting documents.

**Receipt Requirements:**

- Dated, itemised and type of service
- Name, surname of the client/patient
- Signed and stamped by the practitioner

**For Glasses or Lenses:**

Attach a copy of the prescription

**Reimbursement:**

Fees reimbursed per policy limits

**Submit To:**

- **Email:**  
enquiries@hsfhealthplan.com.mt
- **Postal Address:**  
HSF Health Plan (Malta), No.4 Triq Saint' Andrija,  
Valletta VLT 1341, Malta
- **Queries:**  
Call +356 2778 0685 or  
email enquiries@hsfhealthplan.com.mt

## 1 Personal Details of the Insured

<b>Title</b>	<input type="text"/>
<b>Name and Surname</b>	<input type="text"/>
<b>ID Card No.</b>	<input type="text"/>
<b>Date of Birth</b>	<input type="text"/>
<b>Address</b>	<input type="text"/>
<b>Telephone Number</b>	<input type="text"/>
<b>Email Address</b>	<input type="text"/>

## 2 Claim Details

▼ Please tick the appropriate box to indicate the nature of your claim(s).

Dental

Receipt Date

Optical

Amount Paid €

## 3 Bank Account Details

▼ Please note: Claims will be settled exclusively via bank transfers. Please provide your bank account details below.

Name and Surname

ID Card No.

IBAN No.

Name of Bank

Country

BIC/SWIFT (foreign bank accounts only):

Date

Signature of Account holder

Tick this box to confirm all your details above are correct.

Please read the Terms and Conditions and Privacy Notice in the Policy document provided to you as part of your Welcome Pack. Both are also available on our website: [www.hsfhealthplan.com.mt](http://www.hsfhealthplan.com.mt).

## 4 Signature

▼ If verification of my claim is required, I authorise HSF Health Plan (Malta) Limited to contact the relevant clinical practitioner and authorise them to provide necessary information for processing my claim. I declare that all information provided to HSF Health Plan (Malta) is true and correct to the best of my knowledge.

Name

Date

Signature

Tick this box to confirm all your details above are correct.